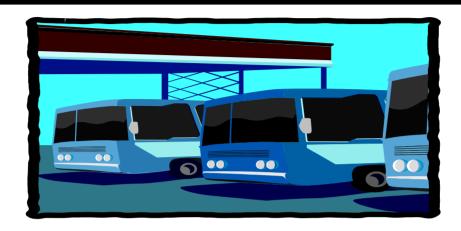
AUGUSTA PUBLIC TRANSIT

ADA PARATRANSIT APPLICATION



Thank you for your interest in Augusta Public Transit's (APT) Paratransit Van Service. This curb to curb van service is available to qualifying persons with permanent or temporary disabilities.

To qualify for Paratransit services you must fill out an application. The first part is for the applicant and the second part is for a health care professional. After the receipt of a completed application there will be a 21 day processing period. After the processing period is finished notification will be sent by letter on the status of the application. If the application is submitted incomplete it will not be processed.

The User Guidelines Handbook should be read and the last sheet of the handbook must be returned with the applicants signature and date. If it is not returned the application will not be processed.

Send all completed forms to:

Augusta Public Transit ADA Office 1535 Fenwick Street Augusta, GA 30904 Office: 821-1819

Fax: 821-1752

ALL CITY FIXED ROUTE BUSES ARE WHEELCHAIR ACCESSIBLE

PART A APPLICANT INF	ORMATION (PLEASE PRINT)) DATE
Please check one Initia	al Application	Recertification
Last Name	First Name	Middle Initial
Street Address		
City	Georgia	Zip Code
Email Address		
Name of Subdivision or Ap	artment Complex	
Nearest Major Intersecting	Street	
Nearest Cross Street to You	nr Residence	
Day Phone Number	Evening	Phone Number
Cell Phone Number		
Date of Birth	Male	Female
In Case of Emergency Co	ntact	
Name	Relationship	
Day Phone Number	Evening	Phone Number
Medical Name of Your Dis	ability	
Is Your Disability		
O Permanent		
O Temporary		
O I don't Know		
If temporary, please indicat	e how long you believe the temp	orary disability will continue.
2 Months	3 Months 6 Mont	hs Other

How does your disabilit very specific.	y affect your ability t	o ride the regular fixed r	oute bus service? Be
			
		ies that impact your FUNC	
If you answered yes, plea	se explain		
Do any of the following of	conditions affect your	travel? Please explain.	
Hills			
No Curb Cuts			
No Sidewalks			
_	evice(s) you use when support device.	traveling or walking outsic	
Walker	Braces	Support Cane	Crutches
Prosthesis	Scooter	Manual Wheelchair	Motorized Wheelchair
Service Animal	What type of animal what function does the	is used? he animal provide?	
If you use a manual whe	elchair and a motoriz	ed wheelchair/scooter list	dimensions separately.
DIMENSIONS OF WH	EELCHAIR/SCOOT	TER	
Length (back to front)	inches	Width (wheel to whe	el)inches
Weight (include wheelch that will be placed on the	air, person, any medic wheelchair at the tin	cal devices such as oxygen ne of transportation)	, etc. and all other items lbs.
Wheelchair Name/Bra	and	Model Number	

How far from	n your home is the nearest public transit bus stop?			
OLess	than 1 block O 1 to 2 Blocks O 3 to 4 Blocks O 5 or More Blocks			
On your own	or using a support device, are you able to get to and from the public transit bus stop home? Yes No Sometimes—Describe the circumstances			
How often d	o you travel on public transit buses?			
O Dail	y O Weekly O Monthly O Occasionally O Never			
Have you ev	er used a public transit bus in the past?When did you stop?			
Why did you	stop traveling by public transit bus?			
	k up steps on a bus? Yes No			
	he lift on a bus?			
Are you able to identify and understand the destination and route number signs on public transit buses?				
	\circ Yes \circ No			
	Only when the Bus Operator announces them			
	Sometimes—describe the circumstances			
Are you able	to determine when you have reached your destination to get off the public transit bus?			
	O Yes O No			
	Only when the Bus Operator announces them			
	Sometimes—describe the circumstances			

From the following list, please check off all of the disabilities or symptoms that prevent you from boarding, riding or disembarking from public transit buses.

Cardiovascular/Pulmonary	Neuromuscular
Angina	ALS/Lou Gehrig's Disease
Arteriosclerosis/Atherosclerosis	Cerebral Palsy
Asthma	Charcot-Marie Tooth Syndrome
Bypass Surgery Date	Equilibrium
Chronic Obstructive Pulmonary Disease	Fibromyalgia
Congestive Heart Failure	Hemiplegia/Hemiparesis
Cystic Fibrosis	Multiple Sclerosis
Emphysema	Muscular Dystrophy
Heart Attack Date	Neuropathy
HTN/Hypertension	Paraplegia
Peripheral Vascular Disease	Parkinson's Disease
Phlebitis	Polio
Thrombosis	Quadriplegia
Other	Sciatica
	Spina Bifida
	Stroke/Cerebral Trauma Date
General Medicine	TIA's (Transient Ischemic Attack)
AIDS	Other
Atrophy	
Chemotherapy	
Diabetes	Orthopedic
Edema	Amputation (specify)
Epilepsy	Broken/Fracture Date
Lupus	Degenerative Joint Disease
Rheumatoid Arthritis	Gout
Vidnov Dialygia	Hip Replacement
Radiation Treatment	Knee Replacement
Other	Osteoarthritis
	Osteoporosis
	Scoliosis
Vision (specify) One Eye Both Eyes	Spondylitis
Cataracts	Other
Cortical Blindness	
Glaucoma	
	Cognitive/Psychological
Patinal Datachment	Alzheimer's Disease
T 11 D1' 1	ADD/Attention Deficit Disorder
T + 11 D1: 1	Autism
	Dementia
Other	Head Trauma
	Mental Retardation
	Panic Disorder
	Schizophrenia
	Other
	VILIA

For each disability checked on previous page, please describe how it prevents you from boarding, riding or disembarking from public transit buses.				
Can you wait at a APT bus sto	p?			
If no, please explain why				
How far can you walk without	the assistance of another person?			
Less than 100 feet	200 - 400 feet			
800 - 1000 feet	Over 1000 feet Do Not Need Assistance			
How do you travel now? Pleas	se check all that apply.			
O Wheelchair/Scooter	O Pushed by PCA Pushed by Self			
O Walk	O Drive Myself			
O Passenger in someone e	else's vehicle			
Regular Fixed Route B	us			
Other Van Service				

Do you currently travel with a Personal Care Attendant (PCA), a person who assists you regularly with boarding and exiting the vehicle when you travel?
O Yes O No
What type of assistance does your PCA provide related to transportation
Name (s) of Personal Care Attendant (PCA)
If you do not require a personal care attendant (PCA) for boarding and exiting the bus, are you required to be met by a caregiver when existing the bus?
\circ_{Yes} \circ_{No}
If the bus arrives at your destination and the caregiver is not there to take you off the bus, who must be contacted? Name
Please note: If contact number does not answer or is disconnected, 911 will be called to take the passenger off the bus.

I have reviewed all the information contained in this application. I certify that all the information is true and correct to the best of my knowledge and ability. I understand that falsification of information may result in denial of service. I understand that only the information required to provide Paratransit services will be disclosed to those who perform those services. I understand that if any portion of this application changes, including mobility devices, I will notify the Augusta Public Transit ADA Office immediately. I understand that Augusta Public Transit may contact the licensed professional who has completed the Professional Verification Form attached to this application in order to confirm or clarify this information. I hereby authorize release of this medical information as requested by Augusta Public Transit for a period of three (3) years from this date.

Applicant Signature:		
Date:		
If a person other than the ap	•	•
•	given to me by the appli	application is true and correct based cant.
•	1	application is true and correct based ealth condition or disability.
PRINT NAME:		
SIGNATURE:		
RELATIONSHIP TO AP	PLICANT:	
TELEPHONE:	(DAY)	(EVENING)

PART B

LICENSED PROFESSIONAL VERIFICATION

Dear Licensed Professional:

The Americans with Disabilities Act (ADA) of 1990 is a civil rights bill prohibiting discrimination against people with disabilities. In accordance with the Act, Augusta Public Transit offers a curb-to-curb bus service for those who cannot use the regular fixed-route Augusta Public Transit buses.

Passengers must be certified eligible in order to use the curb-to-curb bus service. Applicants may be found eligible for this bus service for some trip requests but not for all trips they request. Eligibility is based upon a functional inability to use the regular transit service.

All regular fixed-route buses are equipped with a lift/low floors for people who use a wheelchair or cannot climb stairs.

The information you provide, along with the applicant's information, will enable us to make a appropriate determination. All information will be kept confidential.

Thank you for your assistance.

Augusta Public Transit ADA Paratransit System 1535 Fenwick Street Augusta, Georgia 30904 (706) 821-1819

LICENSED PROFESSIONAL VERIFICATION

La	Last Name First Name Date of Last Visit (mm/dd/yy)					
Da						
Mo	Medical Diagnosis of Disability Is this condition temporary?					
) Is 1						
	Yes If yes, for how long? No		(days/weeks/months)			
2) Is 1	the disability episodic? OYes	No				
, and the same of						
Ple	ease discuss how this disability affects the application	nt's mobility.				
3) Ple	ease discuss how this disability affects the application	nt's mobility				
	ease discuss how this disability affects the applications and the sease discuss how this disability affects the applications are seased in the sease discuss how this disability affects the applications are seased in the seased					
	bes the applicant have the mental capacity, visual a	acuity and/or	hearing ability to:			
	pes the applicant have the mental capacity, visual a a) Provide address and telephone number?	acuity and/or	hearing ability to:			
	pes the applicant have the mental capacity, visual a a) Provide address and telephone number? b) Recognize a destination or landmark?	acuity and/or Yes Yes	hearing ability to: No No			

5)) How far can the applicant walk without the assistance of another person?						
	0	1 City Blo	ck (1/10) mile)	C)	4 to 6 City Blocks (1/2 mile)
	0	2 to 4 City	Blocks	(1/4 mile)	C)	6 to 8 City Blocks (3/4 mile)
6)	Does th	e applicant	require a	personal care	attendant (PC	CA) for boarding and exiting the vehicle?
	0	Yes	O 1	No			
	Licen	sed Profe	ssional	's Informati	on		
	Full N	ame:					
	Title:						
	Clinic/	Business:					
	Street	Address:					
	City:			State:			Zip Code:
	Teleph	ione:			Fax	N	o:
	E-mail	I					
	Professional License, Registration or Certification Number:						
	Agency Issuing License/Certification:						
for	mation i	is true and c	orrect to	the best of my	knowledg	e a	olication and hereby certify that all the in- and ability. I certify that the applicant _, is under my professional care. I hereby
Sig	nature:_						
Da	te:						

APPLICANT CHECKLIST

Before mailing the paratransit application form, please complete the following checklist:					
☐ Did you review the application carefully?					
☐ Did you review the eligibility requirements carefully?					
□ Did you fill out the form correctly?					
Did you fill out the form completely?					
Remember: Any incomplete forms will be returned without being processed.					
☐ Did you complete all questions in Part A and signed it?					
☐ If applicable, has the person who assisted you signed and dated Part A of the application?					
☐ Has a licensed professional completed all the questions in Part B of the application?					
☐ Did you review the enclosed User Guideline Handbook?					
☐ Did you sign the back page of the User Guideline Handbook and attach it to the Application?					

If you have any questions, please contact ADA Paratransit between 8:30 a.m. and 5:00 p.m., Monday through Friday.

(706) 821-1819

APPLICATIONS WILL BE RETURNED IF ANY OF THE ABOVE PROCEDURES ARE NOT FOLLOWED.

